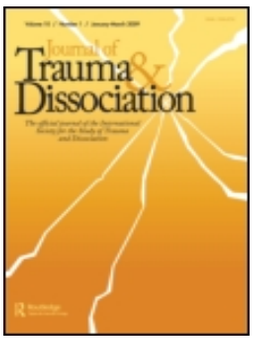

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Journal of Trauma & Dissociation

ISSN: 1529-9732 (Print) 1529-9740 (Online) Journal homepage: https://www.tandfonline.com/loi/wjtd20

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To cite this article: Jennifer M. Gómez, Jenn K. Lewis, Laura K. Noll, Alec M. Smidt & Pamela J. Birrell (2016) Shifting the focus: Nonpathologizing approaches to healing from betrayal trauma through an emphasis on relational care, Journal of Trauma & Dissociation, 17:2, 165-185, DOI: 10.1080/15299732.2016.1103104

To link to this article: https://doi.org/10.1080/15299732.2016.1103104

JOURNAL OF TRAUMA & DISSOCIATION
2016, VOL. 17, NO. 2, 165–185
http://dx.doi.org/10.1080/15299732.2016.1103104

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SPECIAL SECTION ARTICLE

Shifting the focus: Nonpathologizing approaches to healing from betrayal trauma through an emphasis on relational care

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ABSTRACT

As the diagnosis and treatment of mental disorders has become increasingly medicalized (Conrad & Slodden, 2013), consideration for the relational nature of trauma has been minimized in the healing process. As psychiatrist R. D. Laing (1971) outlined in his essays, the medical model is an approach to pathology that seeks to find medical treatments for symptoms and syndromes based on categorized diagnoses. We argue that such a model implicitly locates the pathology of trauma within the individual instead of within the person(s) who perpetrated the harm or the social and societal contexts in which it took place. In this article, we argue that this framework is pathologizing insofar as it both prioritizes symptom reduction as the goal of treatment and minimizes the significance of relational harm. After providing a brief overview of betrayal trauma (Freyd, 1996) and the importance of relational processes in healing, we describe standard treatments for betrayal trauma that are grounded in the medical model. In discussing the limitations of this framework, we offer an alternative to the medicalization of trauma-related distress: relational cultural therapy (e.g., Miller & Stiver, 1997). Within this nonpathologizing framework, we highlight the importance of attending to contextual, societal, and cultural influences of trauma as well as how these influences might impact the therapeutic relationship. We then detail extratherapeutic options as additional nonpathologizing avenues for healing, as freedom to choose among a variety of options may be particularly liberating for people who have experienced trauma. Finally, we discuss the complex process of truly healing from betrayal trauma.

ARTICLE HISTORY
Received 31 December 2014
Accepted 5 July 2015

KEYWORDS
Betrayal trauma; healing; interpersonal trauma; nonpathologizing treatment; relational cultural theory; relational trauma

What does it mean to heal from trauma, and how might that change if the trauma is relational? Over the past century, the diagnosis of mental disorders has become increasingly medicalized (Conrad & Slodden, 2013). The medical model prescribes treatment—and thus defines healing—not only for some diagnoses, such as depression and schizophrenia, but also for individuals who have experienced interpersonal trauma. Trauma treatments grounded in this paradigm implicitly

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locate the pathology of trauma within the individual—often an individual who has been deeply betrayed—instead of within the person(s) or environment(s) responsible for the betrayal. In this article, we argue that this framework is pathologizing insofar as it both privileges symptom reduction as the primary goal of treatment and minimizes the significance of relational harm. In the therapeutic context, to pathologize is to regard psychological distress as abnormal or unhealthy and thus in need of treatment or management. A nonpathologizing model of trauma takes the stance that the abnormality is in the situation and not in the person. When the trauma is relational, it is the nature of the act that is unhealthy and not the individual who has experienced the act. A nonpathologizing model of therapy takes the stance that the person is greater than his or her problems and makes room for compassion through acknowledging the role of outside variables, such as relationships and environments, in the initial harm and the subsequent process of healing from the trauma.

After providing a brief overview of betrayal trauma (Freyd, 1996) and the importance of relational processes in healing, we describe standard treatments for betrayal trauma that are grounded in the medical model. We discuss the limitations of this framework and offer one alternative to the medicalization of trauma-related distress: relational cultural therapy (RCT). Within this nonpathologizing framework, we highlight the importance of attending to contextual, societal, and cultural influences of trauma-related distress as well as how these influences might impact the therapeutic relationship. Furthermore, we describe avenues for healing outside of therapy that those who have experienced betrayal trauma can explore. In this exploration of alternative approaches to betrayal and traumatic distress, we ultimately address the following question: How is healing from betrayal trauma possible today?

What is trauma?

Relational trauma is a specific category of psychological trauma that involves an overwhelming rupture within a significant relationship on which the individual depends for emotional, physical, or spiritual well-being. Relational trauma, by definition, involves loss and like all traumatic events "overwhelm[s] the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, 1997, p. 33). Although the losses implicated in relational trauma do not always involve maltreatment (as in the sudden death of a caregiver), in experiences of abuse, neglect, or abandonment[1] they may also represent violations of trust. When the latter is the case, *betrayal trauma* has occurred.

First introduced by Freyd (1991), the term *betrayal trauma* denotes a social dimension of trauma in which "the people or institutions on which a person depends for survival significantly violate that person's trust or well-being" (Freyd, 2008, p. 76). Childhood abuse, infidelity, discrimination, and

workplace exploitation are examples of betrayal trauma. It is important to note that betrayal trauma theory holds that the extent to which a given experience involves a betrayal by a close and trusted other impacts the way that experience is encoded and recalled (Sivers, Schooler, & Freyd, 2002) and thus has important implications for an understanding of betrayal trauma and healing processes.

Betrayal has not historically been included in diagnostic nosology. Betrayal trauma refers to relational trauma *independent* of posttraumatic stress reactions (Freyd, 1996), and ample empirical evidence suggests that betrayal plays an important role in the etiology of posttraumatic sequelae (e.g., DePrince et al., 2012; Gómez, Smith, & Freyd, 2014; Kelley, Weathers, Mason, & Pruneau, 2012). Thus, addressing experience(s) of relational rupture (e.g., betrayal) may be an important part of healing from betrayal trauma.

Betrayal trauma is extraordinary but common

In recent years, conceptualizations of betrayal trauma have changed dramatically as increasing attention has been paid to the role of childhood adversity in affecting mental and physical health outcomes later in life (e.g., Anda et al., 2006; Felitti et al., 1998). Although extraordinary in their significance, relational and betrayal traumas are now regarded as common experiences (e.g., Goldberg & Freyd, 2006) that may occur at any point during the lifespan—beginning in early infancy when human beings are most dependent on their caregivers for survival. The prevalence of exposure to betrayal trauma in childhood is so high that it has been described as a silent epidemic (Kaffman, 2009). Herman (1997) aptly noted that traumatic "events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life" (p. 33).

The role of attachment in betrayal trauma

One important so-called ordinary human adaptation that may be overwhelmed by betrayal trauma is the attachment system, which serves to maintain proximity and relational closeness with important figures in one's life (Bowlby, 1969). Although trauma may impact a person's connections with others at any time, betrayal trauma during infancy may be particularly detrimental, as it is during this sensitive developmental period that individuals begin to develop their internal working models for social relationships. Early betrayal trauma in the form of unavailable, inconsistent, or abusive caregivers may leave infants (who have yet to develop the ability to regulate intense emotions on their own) alone with overwhelmingly negative affects and interfere with their ability to form secure attachments with others (Shore, 2008). Regardless of when the trauma occurs, the experience of

being rendered powerless by betrayal, within a relationship on which an individual depends, challenges one of the most basic human survival mechanisms—one's orientation toward connection with others.

Conceptualizations of trauma in the medical model

The relationship between relational powerlessness and betrayal highlights the core distinction between instances of betrayal trauma and other traumatic experiences (e.g., Freyd, 1996, 1999). It is important that helping professionals working with individuals who have experienced betrayal trauma consider these distinctions when individuals approach them seeking support in their healing process.

Psychiatric nosology and standard treatment

Despite efforts to attend to the importance of interpersonal trauma, psychiatric diagnostic nosology still does not adequately distinguish between interpersonal and non-interpersonal trauma. Most significant is that the current edition of the most influential diagnostic text in the United States, the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5;* APA, 2013), added a singular line to the posttraumatic stress disorder (PTSD) diagnostic section related to interpersonal traumas—what Freyd (1996) termed *betrayal trauma*. The line reads, "The disorder may be especially severe or long-lasting when the stressor is interpersonal and intentional" (APA, 2013, p. 275).

Current treatment guidelines—specifically the *Practice Guidelines for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder* published in 2004 by the APA Work Group on ASD [acute stress disorder] and PTSD—outline a stage-oriented approach as the general standard of care when treating individuals who have been exposed to trauma. With a focus on symptom reduction, stages include an initial assessment, psychiatric management, and selection and consideration of an intervention strategy (APA Work Group on ASD and PTSD, 2004). Although this treatment guideline is not representative of every treatment facility or practitioner, it is an influential guideline for standard care and thus represents a common approach to trauma treatment in community and clinical settings. In addition, although a diverse set of practitioners may treat individuals who have experienced betrayal trauma, psychiatry still largely dominates the conceptualizations of trauma, as reflected in the aforementioned guidelines of practice and the main diagnostic text (Burstow, 2003), the *DSM–5* (APA, 2013). Not only does this framework again fail to acknowledge the key distinctions between betrayal trauma and other traumatic experiences, but also the guidelines for practice include potentially pathologizing language

and methods. Thus, these standards create the potential for further harm to those with histories of betrayal trauma.

Diagnostic comorbidity

In most practices and treatment facilities in the United States, a psychiatric diagnosis is required for treatment. This requirement, combined with the insufficient diagnostic scope of the *DSM*, results in individuals with a history of betrayal trauma often receiving multiple diagnoses, both trauma related (e.g., ASD or PTSD) and non–trauma related (e.g., depression or social phobia; Galatzer-Levy, Nickerson, Litz, & Marmar, 2013). Herman (1997) referred to diagnostic comorbidity in this context as the *disguised presentation* of treatment-seeking individuals who have experienced chronic interpersonal trauma. The disguised presentation includes domain-general outcomes of this type of betrayal trauma, which affects individuals relationally and globally.

Outcomes of interpersonal trauma include depression (e.g., Bleich, Koslowsky, Dolev, & Lerer, 1997; Breslau, Davis, Peterson, & Schultz, 2000; Coker et al., 2002; Edwards, Freyd, Dube, Anda, & Felitti, 2012; Goldsmith, Freyd, & DePrince, 2012; Klest, Freyd, & Foynes, 2013; Tang & Freyd, 2012); anxiety (e.g., Edwards et al., 2012; Goldsmith et al., 2012; Kessler, Sonnega, Hughes, & Nelson, 1995; Klest et al., 2013; Springer, Sheridan, Kuo, & Carnes, 2007; Tang & Freyd, 2012); dissociation (e.g., DePrince, Freyd, & Malle, 2007; Freyd & DePrince, 2001; Goldsmith et al., 2012; Gómez, Kaehler, & Freyd, 2014; Klest et al., 2013); borderline personality disorder characteristics (e.g., Kaehler & Freyd, 2009, 2012); self-harm (Ford & Gómez, 2015); tactile, visual, and auditory hallucinations (e.g., Gómez, Kaehler, et al., 2014; Moskowitz, 2011; Read & Argyle, 1999); PTSD symptoms (Kelley et al., 2012; Klest et al., 2013; Tang & Freyd, 2012; Ullman, 2007); and memory and cognitive distortions (e.g., Freyd, 1996; Freyd, DePrince, & Zurbriggen, 2001; Glaser, 2000; Nelson & Carver, 1998; Teicher, 2002). Although these outcomes may occur in isolation, the overwhelming majority of individuals with a history of betrayal trauma experience many forms of distress simultaneously (Gilbert et al., 2009; Ginzburg, Ein-Dor, & Solomon, 2010; Hubbard, Realmuto, Northwood, & Masten, 1995; Perkonigg, Kessler, Storz, & Wittchen, 2000). Herman (1997) proposed complex PTSD—a diagnosis independent of the *DSM–5*'s current diagnostic criteria for PTSD—that unifies outcomes of trauma-related distress resulting from chronic interpersonal trauma. Emerging evidence supports the construct validity of this conceptualization (e.g., Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Sar, 2011).

Regarding available interventions for trauma-related symptoms, there are multiple therapeutic modalities, and evidence-based treatments are increasing in popularity (Sturmey & Hersen, 2012). Once a diagnosis is given, the standardized psychotherapy approaches often include cognitive–behavioral

interventions and/or exposure therapy (Foa, 1997; Hembree & Foa, 2000; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Resick, Nishith, Weaver, Astin, & Feuer, 2002). Other treatments may include eye-movement desensitization and reprocessing, acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), or psychodynamic psychotherapy (Foa, Keane, Friedman, & Cohen, 2008; Foa & Meadows, 1997; PTSD Treatment Guidelines Task Force, 2000).

Medication management

With the medical model as its base, standard treatment for betrayal trauma often involves psychopharmacology, specifically using medication as a management tool for the disguised presentation, described by Herman (1997). Multi-medication management is sometimes used in the goal of symptom reduction. Instead of using an approach that values or highlights an individual's experience and knowledge, various forms of trauma-related distress are treated as if they are disparate disorders as opposed to understandable reactions to betrayal trauma. Although it is difficult to know the exact percentage of cases in which psychopharmacology is used, multiple treatment recommendations often include medication; for instance, Abrams, Lund, Bernardy, and Friedman (2013) found that among veterans being treated for PTSD, 65.7% had been prescribed an antidepressant medication, and Mellman, Clark, and Peacock (2003) found that 77% of patients in a community sample of adults received a prescription for at least one psychotropic medication. This suggests that medication use in the treatment of PTSD is relatively common. Selective serotonin reuptake inhibitors in particular are often a first-line medication for individuals diagnosed with PTSD (Brady et al., 2000; Conner, Sutherland, Tupler, Malik, & Davidson, 1999; Marshal, Beebe, Oldham, & Zaninelli, 2001; Martenyi, Brown, Zhang, Prakash, & Koke, 2002; Tucker et al., 2001). Using medication primarily to manage internal states can reinforce the idea that the problem resides solely within individuals, thus decontextualizing their distress and responses to the betrayal trauma.

Pathologizing language

Alongside the practice of psychiatric management (APA Work Group on ASD and PTSD, 2004), the term *psychiatric management* is itself pathologizing insofar as it portrays people as needing to be managed. Additional language (e.g., *illness, comorbidity*) used to describe the experience of betrayal trauma can be pathologizing as well (Freyd, 2013). Stemming from the foundation of a medical model, the language used to conceptualize ASD and PTSD often frames the diagnoses as illnesses (APA Work Group on ASD

and PTSD, 2004), which implies sickness or bad health. Although this framework can reduce blame on the individual by legitimizing distress, it is inherently pathologizing in that it conveys that the problem and responsibility for the distress lies within the individual. This conceptualization of trauma-related distress, described exceptionally well by Burstow (2005), is inextricably linked with the American dominant cultural belief that the world is an inherently safe place, and therefore there is something wrong with those who experience the world as dangerous.

Minority individuals are not only affected by the current diagnostic system's failure to account for chronic interpersonal trauma but also impacted by the absence of a criterion that recognizes discrimination, such as race incident–based trauma (Bryant-Davis & Ocampo, 2005). Individuals who are subjugated within the dominant American culture on the basis of sexual orientation, race, ethnicity, gender, religion, ability, class, and/or other identity or demographic characteristics often experience microaggressions (Shelton & Delgado-Romero, 2011; Sue, 2010; Sue et al., 2007), a form of societal trauma that may occur throughout an individual's lifespan and compound the effects of other betrayal traumas.

Limitations in the evidence base for standard treatment

Although there is a considerable evidence base for standard PTSD treatments (e.g., Bradley, Greene, Russ, Dutra, & Westen, 2005; Foa et al., 2008; Institute of Medicine, 2006), conflicting data indicate that exposure, cognitive behavioral therapy, and eye-movement desensitization and reprocessing therapies have highly variable nonresponse and dropout rates (Cloitre, Koenen, Cohen, & Han, 2002; McDonagh et al., 2005; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). Moreover, it is worth noting that this evidence base is limited in two additional key respects. First, much of the evidence focuses on symptom reduction of *DSM*-defined outcomes of PTSD, without accounting for types of trauma (e.g., Bisson et al., 2007; Bradley et al., 2005; Foa et al., 2008) or the relational harms that may be associated with betrayal trauma (Birrell & Freyd, 2006; Gómez, Becker-Blease, & Freyd, 2015; Gómez, Kaehler, et al., 2014; Roth, Newman, Pelcovitz, Van Der Kolk, & Mandel, 1997). Second, these evidence-based practices have also been criticized for their failure to recognize the needs of minority, culturally diverse, and underprivileged groups, suggesting that despite positive research results, the interventions may be lacking for several important populations (Brown, 2008; Sue et al., 2006).

Healing through relatedness: RCT

The medical model has provided one way of conceptualizing and treating individuals who have experienced betrayal trauma. An alternative to this model can be found in RCT (Miller, 1976). Emerging within the larger context of feminist therapy (see Brown, 2008b), which was itself born from the feminist movement of the late 1960s and early 1970s, Miller (1976) challenged the traditional individualistic model of psychological development and health as being fundamentally damaging to women. She postulated that women's growth happens in and through relationships. Originally RCT was largely developed by, and practiced with, White, upper class, heterosexual women. Subsequent years of theory building and practice have expanded Miller's original concepts, making them applicable to a diverse range of populations, to further encompass individual, familial, societal, cultural, and global connections (e.g., Walker, 2010).

RCT incorporates several core principles that can help one understand that the primary damage of trauma and betrayal is the experience of relational disconnection and not symptoms or disorder. First, growth for all human beings happens in and through interconnection and interdependence within growth-fostering relationships (Miller, 1976). Closely aligned is the second tenet: Disconnections from self, others, cultures, and society at large are the cause of suffering and can result in isolation (Miller & Stiver, 1997). Third, power-over relational dynamics and mutuality are incompatible; disconnections are caused by power-over dynamics that remove agency from the individual, whereas connections are borne out of power-with dynamics that utilize mutuality to cocreate the path toward healing (Bruns & Trimble, 2001; Miller, 1988).

Walker (2010) summarized these complex tasks as follows:

> (1) The goal of therapy is not separation or autonomous power. Rather, the goal is increased initiative and response capability within relationship.
>
> (2) Chronic disconnection … is the primary source of human suffering. Such suffering gives rise to the relational paradox, a deep-seated yearning for connection along with a near-primal terror of the vulnerabilities inherent in connection … Together the client and therapist develop practices for engaging the dialectic of power and vulnerability.
>
> (3) The treatment process requires direct engagement with operative power dynamics … The schemata held by the therapist and the clients are interrogated through the treatment process. Movement toward healing represents a transformation of the power dynamics that shape the client-therapist relationship. (p. 42)

The core tenets of RCT posit that disconnection is at the root of problems for those who have suffered betrayal trauma. By focusing almost exclusively on symptom reduction, standard treatments may increase the disconnection that survivors feel (Birrell & Freyd, 2006). As an alternative to standard treatments, RCT takes a stance against decontextualized, departicularized, disconnected, and separate-self decision making (Birrell, 2011).

Ingrained in this stance is mutuality, another concept central to RCT theory and practice. Jordan (1986) described the experience of mutuality as one by which "one extends oneself out to the other and is also receptive to the impact of the other" (p. 82). Jordan (1986) went on to state that in mutuality "there is openness to influence, emotional availability, and a constantly changing pattern of responding to and affecting the other's state. There is both receptivity and active initiative toward the other" (p. 82). From a practice standpoint, Miller and Stiver (1997) emphasized that mutuality "does not mean sameness, equality, or reciprocity; it is a way of relating, a shared activity in which each (or all) of the people involved are participating as fully as possible" (p. 43).

If authentic connection and the reparation of disconnections through mutual empathy are the source of healing and growth, and chronic disconnections are the primary source of suffering, then every moment in therapy becomes an important moment of connection (Birrell, 2006, 2011; Miller & Stiver, 1994, 1997). To accomplish this in the RCT framework, every therapeutic step requires placing mutuality, connection, and authenticity at the center of the clinical and ethical model (Bergum & Dossetor, 2005; Birrell, 2006; Miller & Stiver, 1997; Walker, 2001). Birrell (2011) has extended these facets of the RCT therapeutic framework to the idea of a relational ethic. She has argued that there are three dimensions that must be addressed to come to a true relational ethic: power, compassion, and the ability to be with uncertainty in relational space. The ethics of relational engagement consist of full presence—not only to the other but also to the self and to the space between.

This is an aspect of the RCT concept of authenticity, referred to earlier (Miller et al., 1999). In RCT, *authenticity* is defined as "a person's ongoing ability to represent … [himself or herself] … in relationships more fully" (Miller et al., 1999, p. 5). It also means being present with one's whole being, with the ability to listen not only to verbal and nonverbal communications but also to the space between (Bergum & Dossetor, 2005; Winnicott, 1971). It is only through one's own authenticity that he or she can invite the other to be truly authentic (Miller et al., 1999).

From the RCT perspective, the goal of therapy is connection through mutual empathy (Jordan, 2010), not repair; individuals need not be conceptualized as broken people who need to be fixed. The connection itself is the healing agent, as those who have experienced betrayal trauma have suffered fundamental disconnection. Growth then occurs through connections in the therapeutic relationship. Simultaneously, the therapist also grows in this ever-expanding, empathetic connection.

This type of relational growth is therapeutically beneficial, with the therapist (Wampold, 2006) and therapeutic relational factors playing important roles in alleviating distress (e.g., Castonguay & Beutler, 2006b; Goldfried & Davila, 2005; Lambert & Barley, 2001). For instance, relational factors, such

as the therapeutic alliance (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Castonguay & Beutler, 2006a; Castonguay, Constantino, & Holforth, 2006; Constantino, Arnow, Blasey, & Agras, 2005; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Falkenström, Granström, & Holmqvist, 2013; Goldfried & Davila, 2005; Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000; Norcross & Hill, 2002; Shirk & Karver, 2003; Summers & Barber, 2003), empathy (Conway, 2014; Elliott, Bohart, Watson, & Greenberg, 2011; Greenberg, Watson, Elliot, & Bohart, 2001; Keijsers, Schaap, & Hoogduin, 2000; Lambert & Barley, 2001; Norcross & Hill, 2004; Orlinsky, Grave, & Parks, 1994; Reynolds & Scott, 1999), genuineness/authenticity (Keijsers et al., 2000; Kolden, Klein, Wang, & Austin, 2011; Norcross & Hill, 2004), and the ability to repair relational ruptures/disconnections (Norcross & Hill, 2004; Safran, Muran, & Eubanks-Carter, 2011), are important for therapy outcomes independent of treatment modality (Castonguay & Beutler, 2006a; Goldfried & Davila, 2005; Holforth & Castonguay, 2005; Norcross & Hill, 2004; Van Beek, 1996). These relational factors—the therapeutic alliance, empathy, genuineness, and the ability to repair disconnections—may be particularly important for individuals who have experienced betrayal trauma (e.g., Birrell & Freyd, 2006; Gómez et al., 2015; Gómez, Kaehler, & Freyd, 2014; Pearce & Pezzot-Pearce, 2013). In addition to utilizing the aforementioned relational factors, RCT appears to operate beyond these factors (Norcross & Wampold, 2011) and to be an effective therapeutic modality in its own right (Oakley et al., 2013). Thus, in offering a nonpathologizing alternative to treatment under the medical model, RCT uses empirically supported relational factors to promote healing from traumatic betrayal.

Contextual considerations in RCT

Oppression in therapy

Within interpersonal therapeutic contexts, strict adherence to rigid protocols can mirror power-over dynamics that remove control from people who have experienced betrayal trauma. Clients who have minority status in the United States, in addition to experiences of betrayal trauma, may be particularly at risk, as cultural oppression within therapy may replicate current and historical societal oppression (see Hays, 2008; Sue, 1978) and unintentional bias may interfere with the therapeutic alliance (Vasquez, 2007). Given that connections, in the context of growth-fostering relationships, are at the heart of RCT, it is important to pay attention to power dynamics within the therapy process that may be exacerbated for those with minority status.

Thus, cultural competency is especially important in RCT because this culture-bound form of healing is centered around reparative relationships. Cultural competence refers to an iterative process of therapists' acceptance of

their own ignorance (Brown, 2008a), acceptance of their role as visitors in clients' inner and outer worlds (Ford, 2008), and acknowledgment of the interplay between societal trauma and the social locations of both therapist and client (e.g., Brown, 2008a). Recognizing and correcting one's mistakes, while examining one's own biases, can potentially mitigate harm that is inevitably perpetrated in the context of therapy operating within a society of inequality.

Contextual influences on trauma

According to Brown (2004), the processes of recovering and healing from trauma need to be framed within the broader contexts in which they occur. For women, this means understanding betrayal trauma through the lens of gendered violence stemming from gender inequality. Thus, feminist theory (Brown, 2004) takes trauma-related distress out of the presumed pathological personality of women and instead places it within the context of cultural misogyny. Therefore, suffering from betrayal trauma is understood through subjugated status in society, likelihood of gendered violence, silencing, and other harms and not from personal deficits (e.g., Burstow, 2005).

It is these assumed personal deficits that individual therapy addresses, by its very framework, largely to the exclusion of outside forces, such as attachment and betrayal (Brown & Freyd, 2008). RCT therapists acknowledge and incorporate the deeply imperfect relational, familial, institutional, cultural, and societal systems that perpetrate—or are complicit in the perpetration of —societal trauma of persons of different cultural backgrounds and social statuses (Comstock et al., 2008). The complexities of the sociocultural context necessitate its inclusion in every aspect of trauma: the implicit and explicit threat of trauma, the trauma(s) itself, the experience of trauma, coping strategies for dealing with trauma, how micro- and macrocommunities understand trauma, and the meaning that individuals place both on the betrayal trauma they have experienced and on themselves.

Utilizing theory and research to understand different experiences of betrayal trauma is paramount in working with individuals with minority status in society. For instance, in addition to betrayal's toxicity in trauma (e.g., DePrince et al., 2012; Gómez, Smith, et al., 2014), cultural betrayal may further impact people who have experienced betrayal trauma (e.g., Gómez & Freyd, 2014). According to cultural betrayal trauma theory (Gómez, 2012, 2015a, 2015b; Gómez & Freyd, 2014), betrayal trauma outcomes further depend on the perceived in-group status of perpetrators for cultural minorities, with intragroup violence including a harmful cultural betrayal. Cultural betrayal trauma theory is just one example of how theory and supporting evidence (e.g., Gómez & Freyd, 2014) can provide routes for examining how the sociocultural context may affect the experience of

trauma. This understanding necessarily impacts how betrayal trauma is addressed and discussed in RCT.

Healing outside of therapy

Although betrayal trauma may negatively affect many parts of an individual and his or her respective life, we believe that healing from even the most severe forms of betrayal trauma is possible. Therapists can engender curiosity within their clients who have experienced betrayal trauma to discover and connect with lost parts of themselves through the experience of mutual empathy in the context of the cocreation of connections in a growth-fostering relationship. Through this process, RCT offers an avenue of healing for individuals who have experienced betrayal trauma. However, relational connections are not, and should not be, relegated only to the therapy room. Indeed, positive, enriching, and nurturing relational connections can happen in conjunction with, independent of, or without formal therapy. These extratherapeutic options are vital to identify when discussing nonpathologizing approaches to trauma; individuals who have experienced betrayal trauma must be allowed and encouraged to identify methods of living, surviving, and thriving that align with their own cultural values, morals, and comfort levels. Where control is pathologizing, freedom to choose among a variety of options may be particularly liberating.

Naturally, avenues for healing outside of therapy will vary across individuals and cultural groups *and* within the same individuals across time and situations. Some of these models of healing have been detailed by Bryant-Davis (2005): journaling/poetry, movement, drama/theater, music, nature, arts and crafts, spirituality, social support, and activism. In addition, in detailing the forms and outcomes of various types of betrayals, Freyd and Birrell (2013) called for emotional support and self-care in processing and healing from betrayal trauma. These activities, and others like them, can help individuals who have experienced betrayal trauma engage in connection with themselves and others in the ways that feel most true to who they are.

Looking forward

In this article, we have discussed a variety of nonpathologizing alternatives to the conceptualizations of healing offered by the medical model. In particular, we argue that the medical model has provided trauma psychology with one framework for healing that is limited in its utility to adequately address what is at stake in experiences of betrayal trauma. Unlike a broken bone, the harms of betrayal trauma necessarily heal differently. To have a broken bone means that previously there was a fully formed bone that was then broken, only to be healed in such a way

that it functions as if previously unbroken. Yet with betrayal trauma, what was broken was not a static entity but rather a dynamically evolving sense of self. As growth occurs relationally from birth, there are no fully formed, psychologically, and traumatically untouched selves to which people can return. Therefore, the following question arises: Is healing from betrayal trauma really possible?

The answer, we believe, depends on the definition of healing. If healing is defined implicitly or explicitly as getting back what was lost or gaining what was never had, those attempting to heal from betrayal trauma may be left feeling weary, incomplete, and at worst betrayed by a framework that invalidates their reality—as one can never be unexposed to trauma. However, we conceptualize healing as the cocreation of a whole being—with hurts, pains, wrongs, strengths, helplessness, vigor, fight, retreat, connection, and integrative and iterative reconnection to self and others. Thus, healing, as understood through an RCT framework, not only is possible in the abstract sense but is in fact a continuous, ever-evolving lived experience that survivors of betrayal trauma can offer themselves in relation with others. Perhaps the gifts that treatment providers could offer, as coparticipants in survivors' healing processes, would be (a) placing betrayal trauma firmly within the relational and sociocultural contexts in which it occurred; (b) actively combating the supposition that pathology lies within those who have experienced betrayal trauma; (c) cocreating growth-fostering relationships with clients in which they can experience connection and mutual empathy; and (d) encouraging clients to explore developing growth-fostering relationships with others outside of the context of therapy through mutuality, respect, and bearing witness to the deepest harms. In doing so, healing from betrayal trauma means truly living.

Notes

1. One could argue that for some, the death of a loved one (even when it occurs by natural or unavoidable causes) may be experienced as abandonment and hence may also involve the experience of a violation in trust. This permanent relational rupture may be particularly disorganizing for children or other individuals who depend on their loved one for both physical and emotional survival.

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